# ALASKA'S BEHAVIORAL HEALTH SYSTEM

*A presentation to the Health Care Commission*

August 15, 2014

# A JOINT PRESENTATION

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# BEHAVIORAL HEALTH SYSTEMS

Alaskans receive mental health and substance use disorder prevention, treatment, and recovery services from federal, state, and private systems of care.

**Community Behavioral Health and Federally Qualified Health Centers**

**Public and Private Hospitals**

**Tribal Health Corporations**

**Veterans Health Administration**

**Department of Corrections**

**Private Providers of Care**


*Yukon Delta From Space (2002)*
courtesy of NASA Earth Observatory

# STATE FUNDED BEHAVIORAL HEALTH SERVICES

Services supported by the State of Alaska include clinical, rehabilitative, and other services throughout the prevention-treatment-recovery spectrum.



# PREVALENCE OF BEHAVIORAL HEALTH DISORDERS

According to the National Survey on Drug Use and Health (2010-2011):

**8.24%** of Alaskan adults are estimated to be dependent upon or abusing alcohol in the past year

**2.39%** of Alaskan adults are estimated to be dependent upon or abusing illicit drugs in the past year

**4.12%** of Alaskan adults are estimated to have a serious mental illness in the past year

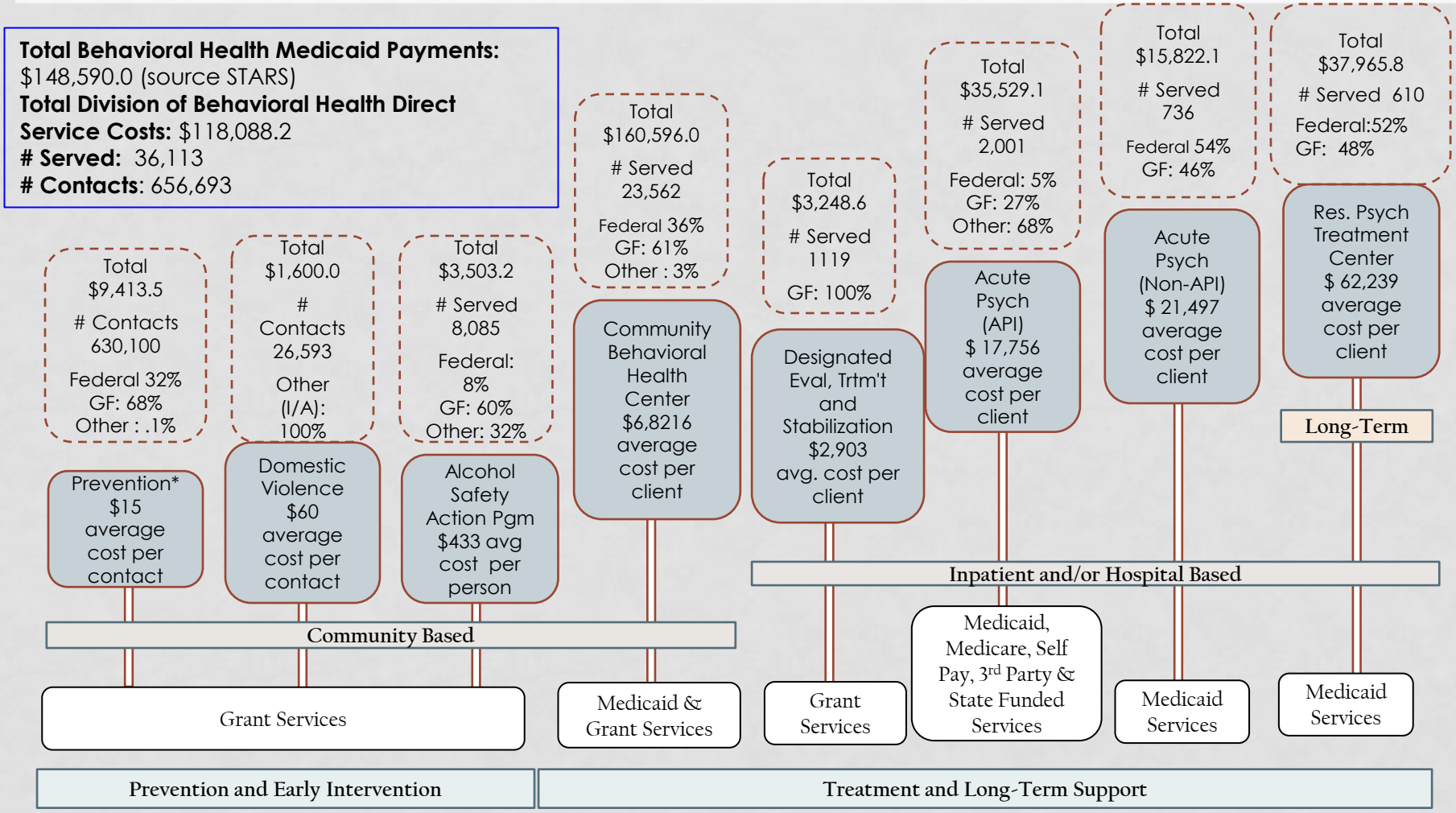
**19.23%** of Alaskan adults are estimated to have any mental illness in the past year

According to the NSDUH (2010-2011), in the month prior to being surveyed:

13.95% of Alaskan adults had used illicit drugs
5.14% of Alaskan adults used pain medication without medical direction
26.04% of Alaskan adults had engaged in binge drinking

# BEHAVIORAL HEALTH SYSTEM (FY12)

**Total Behavioral Health Medicaid Payments:** $148,590.0 (source STARS)
**Total Division of Behavioral Health Direct Service Costs:** $118,088.2
**# Served:** 36,113
**# Contacts**: 656,693




***Source**: Division of Behavioral Health, DHSS (October, 2013)*

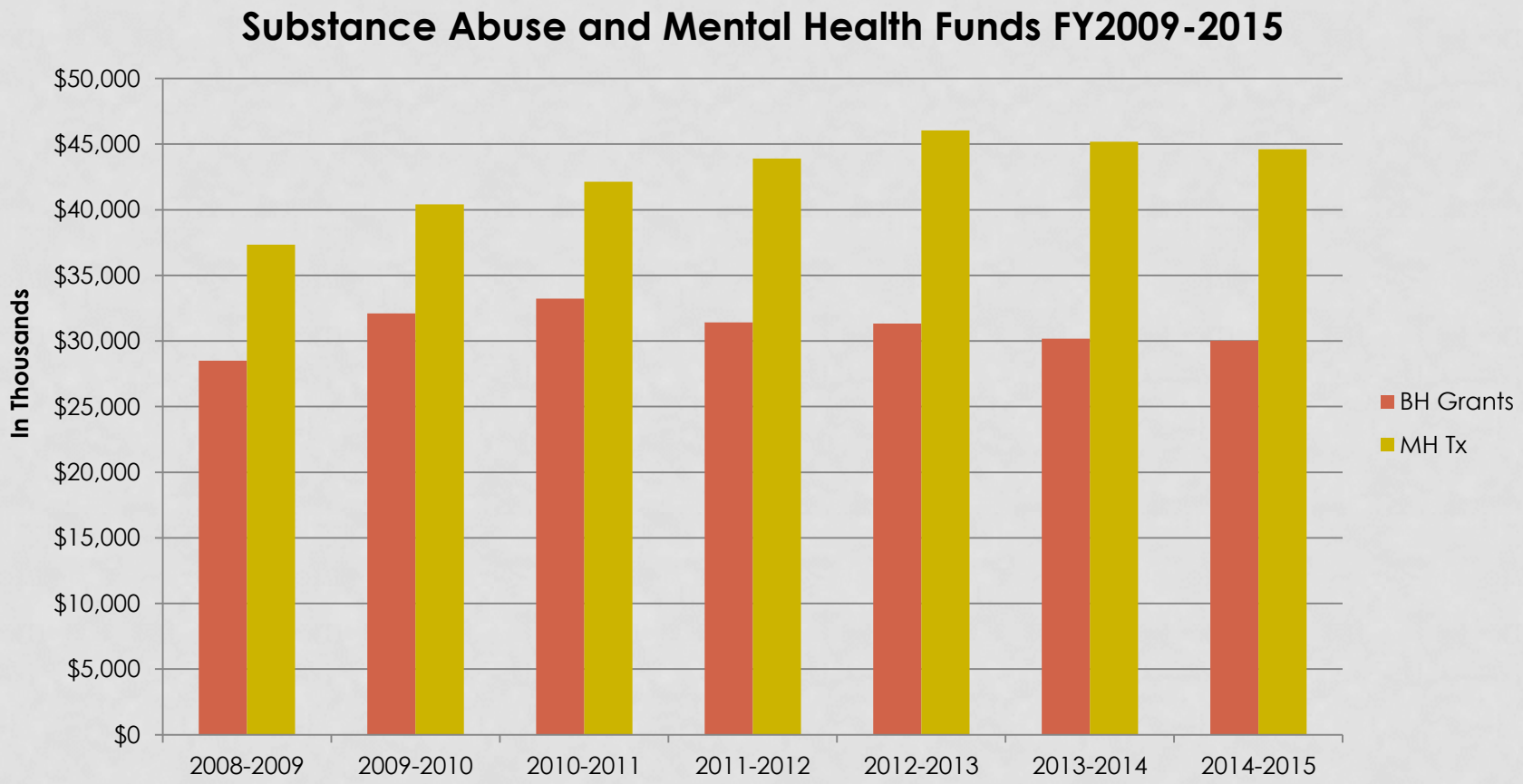
# BEHAVIORAL HEALTH MEDICAID ~ NUMBERS SERVED

| Behavioral Health Medicaid Services | | | | | | |
|---|---|---|---|---|---|---|
| State Fiscal Year | Historical Utilization | | | Annual Percent Change | | |
| | Beneficiaries | Claim Payments (thousands) | Cost per Beneficiary | Beneficiaries | Claim Payments | Cost per Beneficiary |
| 1999 | 8,821 | $56,771.4 | $6,436 | | | |
| 2000 | 10,082 | $67,281.0 | $6,673 | 14.3% | 18.5% | 3.7% |
| 2001 | 10,823 | $80,101.2 | $7,401 | 7.3% | 19.1% | 10.9% |
| 2002 | 11,143 | $90,655.0 | $8,136 | 3.0% | 13.2% | 9.9% |
| 2003 | 12,199 | $107,215.7 | $8,789 | 9.5% | 18.3% | 8.0% |
| 2004 | 12,935 | $119,349.9 | $9,227 | 6.0% | 11.3% | 5.0% |
| 2005 | 13,606 | $129,057.1 | $9,485 | 5.2% | 8.1% | 2.8% |
| 2006 | 12,962 | $134,799.0 | $10,400 | -4.7% | 4.4% | 9.6% |
| 2007 | 12,604 | $138,242.0 | $10,968 | -2.8% | 2.6% | 5.5% |
| 2008 | 11,767 | $125,562.6 | $10,671 | -6.6% | -9.2% | -2.7% |
| 2009 | 11,861 | $133,609.8 | $11,265 | 0.8% | 6.4% | 5.6% |
| 2010 | 12,083 | $148,331.5 | $12,276 | 1.9% | 11.0% | 9.0% |
| 2011 | 12,798 | $154,099.8 | $12,041 | 5.9% | 3.9% | -1.9% |
| 2012 | 13,127 | $152,445.8 | $11,613 | 2.6% | -1.1% | -3.6% |

Source: MMIS/JUCE

***Source:*** *FY2014 DHSS Budget Overview, at 58.*

# SUBSTANCE ABUSE VS. MENTAL HEALTH GRANT FUNDING



# EPISODE OF CARE

1. Intake
2. Alaska Screening Tool (AST)
3. Integrated Assessment (mental health AND substance abuse)
4. Initial Client Status Review (CSR)
5. Diagnosis
6. Treatment Plan (includes determination of level of care needed)
7. Clinic Services and/or Rehabilitation Services
8. Client Status Review every 4 months, treatment plan update as needed
9. Discharge at completion of treatment
10. Final Client Status Review
11. Behavioral Health Consumer Satisfaction Survey
12. Follow-Up Surveys, Re-engagement (only some providers do this)

# STANDARD OF CARE

Person-Centered
Evidence Based Practices
Culturally Relevant
Trauma Informed
Accessible
Recovery Oriented
Community Based
Holistic


*http://www.nrepp.samhsa.gov/*

# CONTINUOUS QUALITY IMPROVEMENT

Accreditation (CARF, Joint Commission, COA, others)
Professional Standards
Workforce Training and Continuing Education
Use of Data, Analytics
Practice Innovations
    Same Day Access
    Medical Home
Systems Innovations
    Telehealth
    Trauma Informed Care

# TELEMEDICINE - BEHAVIORAL HEALTH

Alaska has three major telehealth systems providing psychiatry and behavioral health services:

Alaska Veterans Administration Health System, Telemedicine

ANTHC coordinates telehealth through the Alaska Federal Health Care Access Network (est. 2001)

AFHCAN Telehealth Solutions

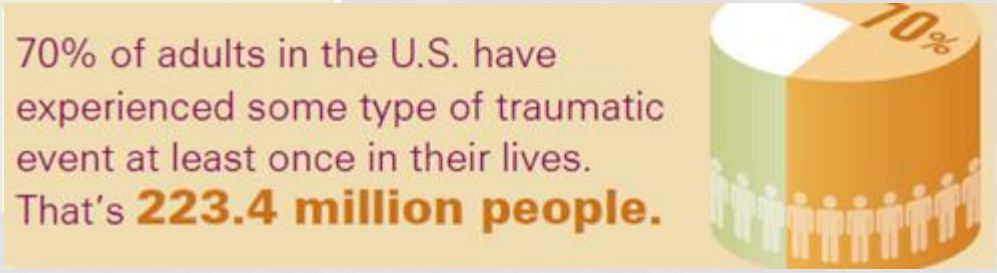
Alaska Psychiatric Institute's Telebehavioral Health Care Services Initiative

FRONTLINE REMOTE ACCESS CLINIC
API Telebehavioral Health Care Services

A-PAL YOUTH MEDICATION CONSULTATION LINE
API Telebehavioral Health Care Services

# TRAUMA INFORMED CARE


Trauma occurs to children and adults, regardless of ethnicity, income, or gender. Adverse Childhood Experiences, rape, sexual assault, historical trauma, combat related stress, domestic violence, community violence – all these contribute to poor health outcomes throughout life.


*Infographics from National Council for Behavioral Health*

# BEHAVIORAL HEALTH AIDES

The Community Health Aide Program was developed in the 1960s in response to a number of health concerns in rural Alaska: the tuberculosis epidemic, high infant mortality, and high rates of injury in rural Alaska.

The need for "culturally-trained behavioral health professionals to provide health prevention, intervention, treatment and continuing care system" in villages was documented in a number of critical reports that detailed the status of behavioral health issues and the behavioral health workforce in the state of Alaska. Under the direction of the Tribal Health Directors, ANTHC used the Community Health Aide Program as a model to train and deploy a workforce of Behavioral Health Aides.

# BEHAVIORAL HEALTH AIDES

BHAs are trained and certified specialists in behavioral health prevention, intervention and postvention.

They have completed specific training, practicum and work requirements, and have gained a breadth of knowledge and skills to support them in their job duties.

BHAs are certified by the Community Health Aide Program Certification Board, a federally-recognized board overseeing all health aide programs/certifications. Like other health professionals, BHAs maintain their certification by completing Continuing Education credits.

BHAs provide a broad range of services under general, direct, and indirect supervision.

# UNDERAGE DRINKING

Comprehensive and consistent prevention efforts in communities and schools have contributed to a decline in youth alcohol use and abuse over the past 20 years.

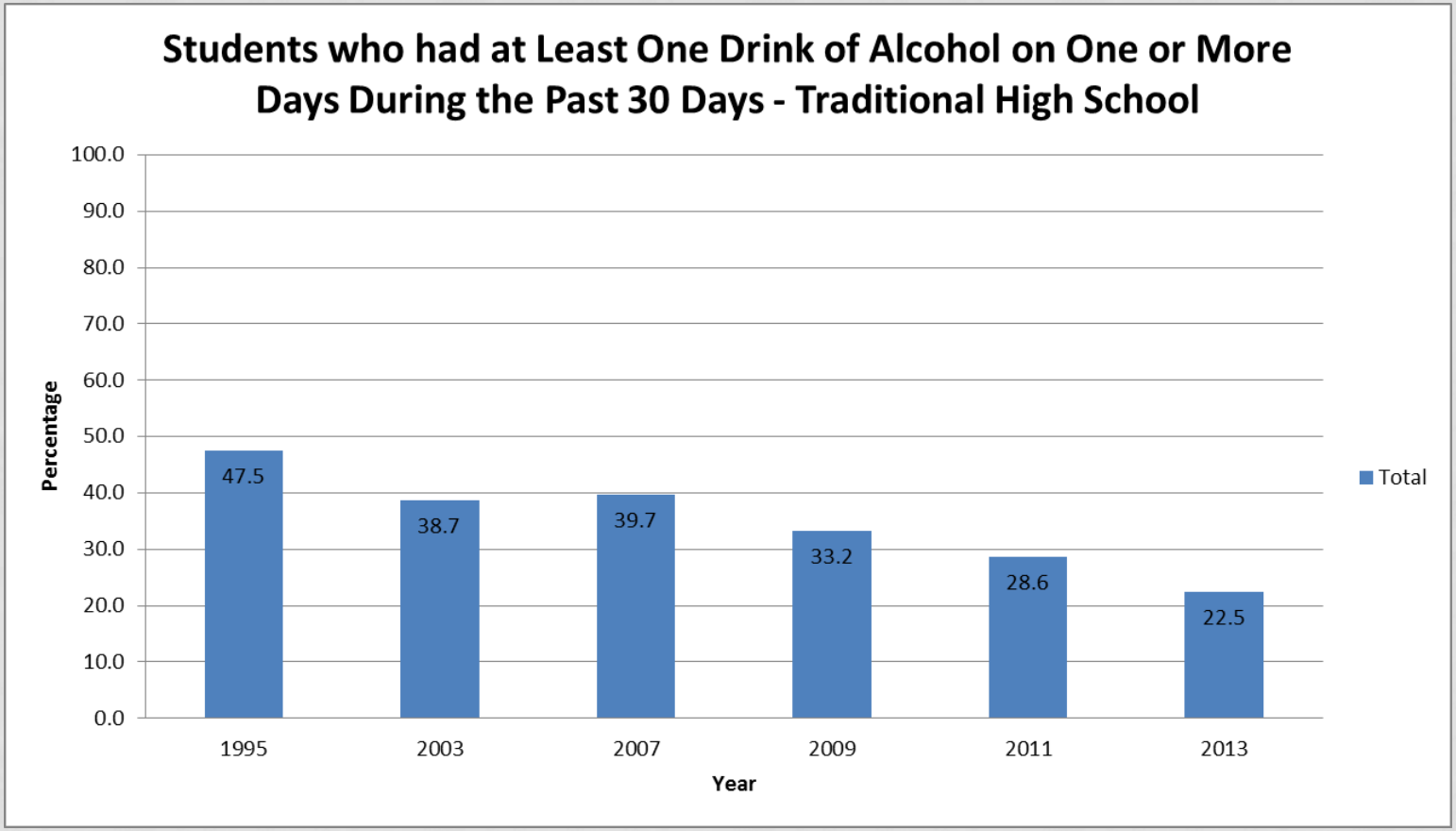
In 1995, 63.3% of students said they had not tried alcohol before age 13. In 2013, 86.3% of youth said they had not tried alcohol before age 13.

In 1995, 52.5% of students said they had not had an alcoholic drink in the past month. In 2013, 77.5% of students said they had not had an alcoholic drink in the past 30 days.

In 1995, 68.7% of traditional high schools students said they had not engaged in binge drinking in the past month. In 2013, 87.2% of traditional high school students said they had not engaged in binge drinking in the past month.

*Data from the Youth Risk Behavior Survey, Alaska Division of Public Health*

# UNDERAGE DRINKING




*Data from the Youth Risk Behavior Survey, Alaska Division of Public Health*

# INTEGRATION OF CARE

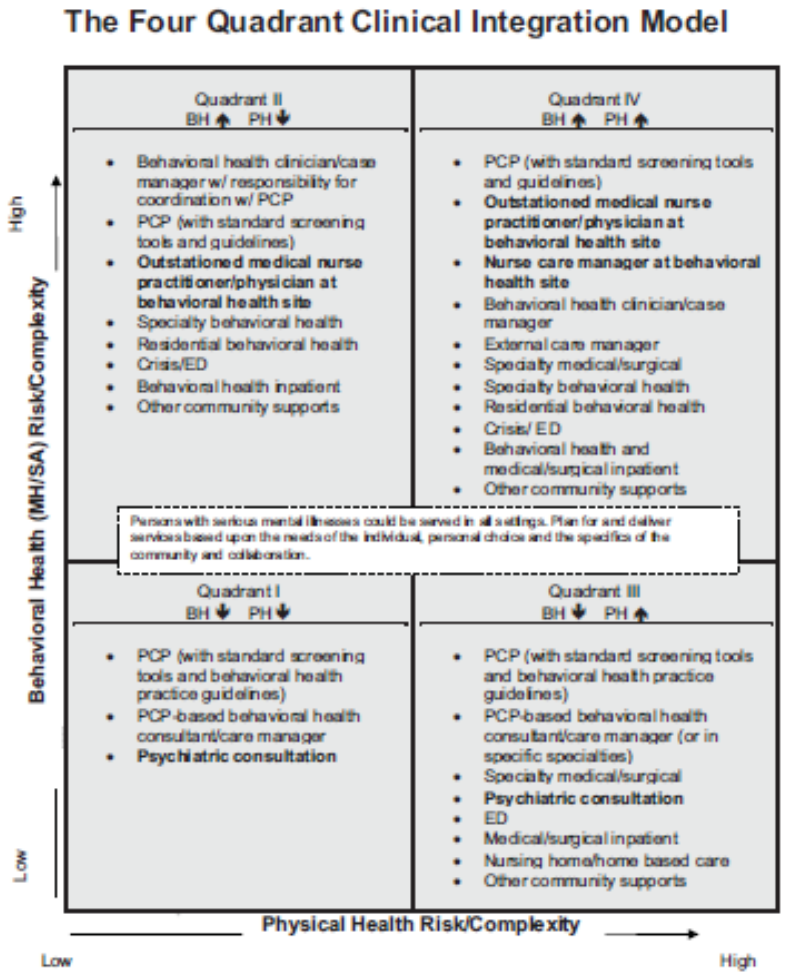
A review of nation-wide Medicaid beneficiaries with disabilities showed a high incidence of co-morbid behavioral health conditions (1 or more):

- 76.2% of those with asthma or COPD
- 73.7% of those with coronary heart disease
- 67.9% of those with diabetes
- 68.6% of those with hypertension

SAMHSA, citing Boyd, C. *et al. Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services* (2011)

Delivering integrated behavioral health and primary care provides a higher standard of care from a more holistic perspective. Tribal health organizations, federally qualified health centers, and community behavioral health centers are all engaged in integrating health services with support from the State of Alaska and federal funders.

# INTEGRATION OF CARE




The Four Quadrant Clinical Integration Model describes levels of integration in terms of primary care complexity and risk and MH/SU complexity and risk. The four quadrant model is a popular way to measure a facility's level of integration.

# CASE STUDY #1 ~ JOHN N.

**John N.** is from a small village in the Bristol Bay Area, Alaska. He is Alaska Native, and just turned 24.

John has had 3 Adverse Childhood Experiences: domestic violence, parent in prison, and substance abusing parents.

The summer John was 23, he experienced a psychotic episode. He was transported to API, where he stayed for 10 days.

John refused to engage in services once home. His condition worsened, and his psychosis returned. He committed a serious crime, was convicted and is now a secure mental health unit in the Department of Corrections.

Costs: $71,008

Transport to API: $3,210 (DET/GF)
API: $17,756 (GF)
Pharmacy: $230 (HIS/Fed)
Lab: $12 (IHS/Fed)
DOC: $49,800/year (GF)

# CASE STUDY #2 ~ APRIL O.

**April O.** is a 30 year old woman living in Seward. She was born and raised there, and is a third generation Alaskan. She is single and has no children.

April was diagnosed with clinical depression when she was 17, after a suicide attempt. Since then, she has had several suicidal episodes requiring hospitalization.

April just recently attempted suicide again, after being diagnosed with MS. April was transported to API, where she stayed for 3 days. When April was discharged, she was again referred to the community behavioral health program. She made an appointment and has resumed therapy and medication.

Costs: $8,255

Transport to API: $1,037 (DET/GF)
API: $4,500 (GF)
Pharmacy: $450 (5 months medication) (self pay/GF/Fed)
Psychotherapy: $2,268 (28 sessions) (GF)

# CASE STUDY #3 ~ JOE M.

**Joe M.** is 22, and has been in the behavioral health system since he was 14.

At the age of 18, Joe attempted to transition from the youth service system to adult services at the tribal health provider. The abrupt move from wrap around therapeutic services and the supports he had at home and at school was too much for Joe, and his mental health deteriorated. The tribal program lacked capacity to provide more than medication management. Joe began to self-medicate with alcohol and marijuana. Joe lost his job and began to isolate from his family. He couldn't keep his apartment, and began couch surfing.

Joe's family got him back into services with the help of NAMI, a peer advocacy group. It took about a year of intensive services to get Joe back on track, Now, he is able to maintain his independence with medication management and monthly group therapy.

Costs Year 1: $49,370 (GF/Fed)

$420 Psychiatric Diagnostic Interview
$1,300 Individual Psychotherapy MH/SUD
$4,100 Group Psychotherapy MH/SUD
$4,800 Pharmacological Management
$550 Case Management
$400 Oral Administration of Medications
$13,600 Social Skills Training
$24,200 Pharmacy

Costs Year 2+: $33,100 (GF/Fed)

$4,800 Pharmacological Management
$4,100 Group Psychotherapy
$24,200 Pharmacy (highest end scenario)

# CHALLENGES

**Challenge:** **Lack of Medicaid reimbursement methodology**

Consequence: Providers reliant on periodic, unpredictable injections of funds
Providers more susceptible to market disruptions
Difficulties recruiting, retaining qualified workforce

What We're Doing: ABHA, DBH, and Office of Rate Review partnering to develop reimbursement methodology

**Challenge:** **Difficulty recruiting, retaining qualified workforce**

Consequence: Reduced access to quality care
High cost locum tenens providers
Low return on human resource investments

What We're Doing: Alaska Health Workforce Coalition
SHARP
Telehealth for service delivery, training, supervision

# CHALLENGES

**Challenge:** **Administrative Burden**

Consequence: Inefficient use of resources
Contributes to practitioner burn out
Diversion of resources from services to administration

What We're Doing: Streamlining Initiative
Grant Reformation (FY16)

# CONSUMER SATISFACTION

Client Status Review

Behavioral Health Consumer Satisfaction Survey

Health Care Organization Surveys

Complaints and Compliments to DBH, AMHB and ABADA, accreditors, CMS

# FOR ADDITIONAL INFORMATION

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# QUESTIONS? COMMENTS?

THANK YOU